Lexington Fayette Urban County Govt
EyeMed Select Plan A, Fixed Fee
Voluntary
Option Base
EyeMed Vision Care in conjunction with Combined Insurance Company of America

Version 7

Vision Care Services	Member Cost In-Network	Out-of-Network Reimbursement*
Exam with Dilation as Necessary	$5 Copay	$27
Fundus Photography Benefit	Up to $39	N/A
Contact Lens Fit and Follow-Up: (Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)		
Standard Contact Lens Fit and Follow-Up:	$0 Copay, Paid-in-full fit and two follow-up visits	$40
Premium Contact Lens Fit and Follow-Up:	$0 Copay, 10% off retail price, then apply $40 allowance	$40
Frames: Any available frame at provider location	$0 Copay; $110 Allowance, 20% off balance over $110	$55
Standard Plastic Lenses		
Single Vision	$5 Copay	$30
Bifocal	$5 Copay	$40
Trifocal	$5 Copay	$60
Lenticular	$5 Copay	$60
Standard Progressive Lens	$70 Copay	$40
Premium Progressive Lens	$70 Copay, 80% of Charge less $120 Allowance	$40
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - Adults	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $110 allowance, 15% off balance over $110	$88
Disposable	$0 Copay; $110 allowance, plus balance over $110	$88
Medically Necessary	$0 Copay, Paid-in-Full	$210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Monthly Rate		
Subscriber	$6.27	
Subscriber + Spouse	$11.81	
Subscriber + Child(ren)	$12.44	
Subscriber + Family	$18.19	

All plans are based on a 24-month contract and a 48-month rate guarantee.
Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate

Additional Discounts:
Member receives a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.
Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.
The contact lens benefit allowance is not applicable to this service.
Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.
Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.
Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group
Rates are valid for groups domiciled in the State of KY.
Fees quoted will be valid until the 1/1/2020 plan implementation date. Date quoted: 5/9/2019.
Rates assume Employer contribution of 20% or less for employees and dependents
Insured Plans are underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York.

Plan Exclusions:
1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
8) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; 9) Services or materials provided by any other group benefit plan providing vision care;
10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If Lexington Fayette Urban County Govt has chosen this benefit design, sign here:

Signature _____ Date _____

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Lexington Fayette Urban County Govt
BASE

Additional discounts

40% OFF Complete pair of prescription eyeglasses

20% OFF Non-prescription sunglasses

20% OFF Remaining balance beyond plan coverage

These discounts are for in-network providers only

Take a sneak peek before enrolling

- You're on the SELECT Network
- For a complete list of **in-network** providers near you, use our **Enhanced** Provider Locator on www.eyemed.com or call **1-866-299-1358**.
- For Lasik providers, call 1-877-5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$5 Co-pay	Up to $27
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay; $110 allowance; 20% off balance over $110	Up to $55
Standard Plastic Lenses		
Single Vision	$5 Co-pay	Up to $30
Bifocal	$5 Co-pay	Up to $40
Trifocal	$5 Co-pay	Up to $60
Standard Progressive Lens	$70	Up to $40
Premium Progressive Lens	$70, 80% of charge less $120 allowance	Up to $40
Lenticular	$5 Co-pay	Up to $60
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	$0 Co-pay Paid-in-Full and two follow up visits	Up to $40
Premium Contact Lens Fit & Follow-Up	$0 Co-pay, 10% off retail price, then apply $40 allowance	Up to $40
Contact Lenses		
Conventional	$0 Co-pay; $110 allowance; 15% off balance over $110	Up to $88
Disposable	$0 Co-pay; $110 allowance; plus balance over $110	Up to $88
Medically Necessary	$0 Co-pay, Paid-in-Full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Underwritten by Combined Insurance Company of America, 111 East Wacker Drive, Chicago, IL 60601, except in New York. CICA Form # VN P63007 0801. The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.

EyeMed℠

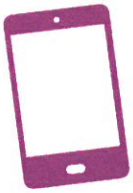
Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam with dilation as necessary (Once every 12 months)	$5 Co-pay	Up to $27
Frames (Once every 12 months)	$0 Co-pay; $110 allowance; 20% off balance over $110	Up to $55
Single Vision Lenses (Once every 12 months) Or **Contacts** (Once every 12 months)	$5 Co-pay $0 Co-pay; $110 allowance; plus balance over $110	Up to $30 Up to $88

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

79% SAVINGS with us*

With EyeMed	Without Insurance**
Exam $5 Co-pay	Exam $106
Frame $163 -$110 allowance $53 -$10.60 (20% discount off balance) $42.40	Frame $163
Lens $5 Co-pay $15 UV treatment add-on +$15 Scratch coating add-on $35	Lens $78 $23 UV treatment add-on +$25 Scratch coating add-on $126
Total $82.40	Total $395



Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.

EyeMed | INDEPENDENT PROVIDER NETWORK + LensCrafters | Pearle Vision | Target Optical | Sears Optical

*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages.